

services. This optional benefit is known as the State plan HCBS benefit. This subpart describes what a State Medicaid plan must provide when the State elects to include the optional benefit, and defines State responsibilities.

§ 441.705 State plan requirements.

A State plan that provides section 1915(i) of the Act State plan home and community-based services must meet the requirements of this subpart.

§ 441.710 State plan home and community-based services under section 1915(i)(1) of the Act.

(a) Home and Community-Based Setting. States must make State plan HCBS available in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to,

daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;

(2) Individuals sharing units have a choice of roommates in that setting; and

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

(D) Individuals are able to have visitors of their choosing at any time;

(E) The setting is physically accessible to the individual; and

(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

(2) Home and community-based settings do not include the following:

(i) A nursing facility.

(ii) An institution for mental diseases.

(iii) An intermediate care facility for individuals with intellectual disabilities.

(iv) A hospital.

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

(3) Compliance and transition:

(i) States submitting state plan amendments for new section 1915(i) of

the Act benefits must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the state plan amendment;

(ii) CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:

(A) For each approved section 1915(i) of the Act benefit subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the renewal or amendment request that sets forth the actions the State will take to bring the specific 1915(i) State plan benefit into compliance with this section. The approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(B) For States that do not have a section 1915(c) waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(iii) A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to

CMS for review and consideration, as follows:

(A) The State must at a minimum provide two (2) statements of public notice and public input procedures.

(B) The State must ensure the full transition plan(s) is available to the public for public comment.

(C) The State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.

(iv) A State must submit to CMS, with the proposed transition plan:

(A) Evidence of the public notice required.

(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.

(v) Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.

(b) *Needs-Based Eligibility Requirement.* Meet needs-based criteria for eligibility for the State plan HCBS benefit, as required in §441.715(a).

(c) *Minimum State plan HCBS Requirement.* Be assessed to require at least one section 1915(i) home and community-based service at a frequency determined by the State, as required in §441.720(a)(5).

(d) *Target Population.* Meet any applicable targeting criteria defined by the State under the authority of paragraph (e)(2) of this section.

(e) *Nonapplication.* The State may elect in the State plan amendment approved under this subpart not to apply the following requirements when determining eligibility:

(1) Section 1902(a)(10)(C)(i)(III) of the Act, pertaining to income and resource eligibility rules for the medically needy living in the community, but only for the purposes of providing State plan HCBS.

(2) Section 1902(a)(10)(B) of the Act, pertaining to comparability of Med-

icaid services, but only for the purposes of providing section 1915(i) State plan HCBS. In the event that a State elects not to apply comparability requirements:

(i) The State must describe the group(s) receiving State plan HCBS, subject to the Secretary's approval. Targeting criteria cannot have the impact of limiting the pool of qualified providers from which an individual would receive services, or have the impact of requiring an individual to receive services from the same entity from which they purchase their housing. These groups must be defined on the basis of any combination of the following:

(A) Age.

(B) Diagnosis.

(C) Disability.

(D) Medicaid Eligibility Group.

(ii) The State may elect in the State plan amendment to limit the availability of specific services defined under the authority of §440.182(c) of this chapter or to vary the amount, duration, or scope of those services, to one or more of the group(s) described in this paragraph.

§441.715 Needs-based criteria and evaluation.

(a) *Needs-based criteria.* The State must establish needs-based criteria for determining an individual's eligibility under the State plan for the HCBS benefit, and may establish needs-based criteria for each specific service. Needs-based criteria are factors used to determine an individual's requirements for support, and may include risk factors. The criteria are not characteristics that describe the individual or the individual's condition. A diagnosis is not a sufficient factor on which to base a determination of need. A criterion can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need.

(b) *More stringent institutional and waiver needs-based criteria.* The State plan HCBS benefit is available only if the State has in effect needs-based criteria (as defined in paragraph (a) of this section), for receipt of services in nursing facilities as defined in section